FORM 50
8M / 2-88

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE WORKMEN'S COMPENSATION ACT

NORTH CAROLINA INDUSTRIAL COMMISSION

RALEIGH

I. C. File No. _____

Emp. Code No. _____

Carrier Code No. _____

Carrier File No. _____

Code numbers furnished each employer and carrier should be inserted before mailing by carrier.

(Refer to I. C. File No. in all correspondence about this injury.)

ITEMIZED STATEMENT OF CHARGE FOR NURSING

Employee _____ Employer _____

Date of Accident _____ 19____ Nature of Injury _____

_____

Indicate below days of service as rendered.

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	

DAYS OF NURSING SERVICE:	8 hour service_____days @_____	
	12 hour service_____days @_____	
	20 hour service_____days @_____	
TOTAL FOR NURSING SERVICE _____		

Who authorized service? _____

(Signed) _____, R. N. or L. P. N.

Dated at _____, 19_____.

Bill for nursing services must be presented in all cases on this form. No other bill for professional services required.

File three copies of this bill with employer or his insurance carrier.